HL Assurance
A Member of the Hong Leong Group

Choice Protect360 Claim Form

The acceptance of this Form is NOT an admission of liability on the part of HL Assurance Pte. Ltd.. Any documentary proof or report required by HL Assurance Pte. Ltd. shall be furnished at the expense of the Policyholder or Claimant.

PARTICULARS OF POLICYHOLDER / INSURED PERSON / CLAIMANT		
Name & Address of Policyholder	Policy No.	Period of Insurance
	Tel No.	H/P No.
	E-mail	Name of Intermediary (if any)
	NRIC/Passport No.	
Name & Address of Insured Person / Claimant (if different from Policyholder)	Tel No.	H/P No.
	Date of Birth	Occupation
	E-mail	Date of Employment
	NRIC/Passport No.	Gender: ( ) Male ( ) Female

PARTICULARS OF THE LOSS / ACCIDENT		
Date, Time and Place of loss	On when and by whom was the loss discovered	Relationship to Policyholder
Explain fully how did the loss / accident occur	Name & Address of any witnesses of the incident	NRIC/Passport No. Tel No.

PERSONAL ACCIDENT (IF APPLICABLE)	
1. Describe in detail the injuries sustained, indicating the part of the body injured and the type of injury (eg. Fracture, cut, bruise, etc.).	
2. Has the same part been injured previously?	( ) Yes ( ) No
3. Name and Address of doctor(s) who treated you and consultation date(s).	
4. Name and Address of your usual family physician.	
5. Details of hospitalization (please attach discharge note & hospital bill): (a) Name of hospital (b) Period of hospitalization	(a) (b) Date Admitted _____ Date Discharged _____
6. Details of Temporary Disability from engaging in or attending to your usual business as a result of the injuries (please attach latest pay slip, medical certificate & medical report): (a) light duties (b) medical leave	(a) From _____ to _____ (c) From _____ to _____

Private & Confidential

Medical Report

(Note: This Report is to be completed by the Attending Physician / Surgeon)

Name of Patient	NRIC/Passport No.	Date of Birth

1. The nature and extent of injuries (if to a limb, state whether right or left)	
2. Is condition due to injury or sickness?	( ) Sickness ( ) Accident on _____ (DD/MM/YY)
3. Are you the Patient's usual Attending Physician? (a) If yes, how long have you know him/her and for what reasons were the medical treatments rendered? (b) If no, was the Patient referred to you by another doctor? If so, please furnish Name and Address of referral doctor.	( ) No ( ) Yes (a) (b)
4. (a) Date you first treated the Patient (b) Of what symptoms did the Patient complain? (c) According to the Patient, how long had he/she been experiencing these symptoms?	(a) (b) (c)
5. In your opinion, how long do you feel the symptoms had lasted?	
6. Had the Patient previously seen any other doctor or receive treatment on account of these symptoms? If so, please give details.	
7. Has the Patient ever experienced any pre-existing condition or symptom at the injured area(s) stated above prior to the accident? If yes, please give details: (i) Nature of pre-existing condition or symptom. (ii) Date on which pre-existing condition/symptom diagnosed. (iii) Cause of the pre-existing condition/symptom.	 (i) (ii) (iii)
7. (a) What was your final diagnosis? (b) Does this injury result in fracture of bones? If yes, which part of the body?	(a) (b)
8. Did Injury or Sickness require: (a) hospitalization? (b) X-rays? (c) Special diagnostic procedure? (d) Surgery?	 (a) ( ) No ( ) Yes Date Admitted _____ Date Discharged _____ (b) ( ) No ( ) Yes (c) ( ) No ( ) Yes (d) ( ) No ( ) Yes Type of Surgery _____
9. Is patient still under your care for this condition?	(a) ( ) No ( ) Yes
10. Bearing in mind the patient's occupation as stated overleaf, do you feel that the injuries or sickness would have prevented him from working?	
11. How long was or will patient be continuously totally disabled (unable to work)?	
12. How long was or will patient be partially disabled?	
13. Give details of any circumstances, such as intoxication, physical defects or medical history which may have contributed to the accident or sickness and/or lengthen the period of disability.	

I hereby certify that I have personally examined and treated the patient for the above *injury/sickness and that the facts as given above are correct.

Signature of Physician / Surgeon _____ Name and Address of Clinic / Hospital _____

Name and Designation _____ Date _____

HOME CONTENTS (IF APPLICABLE)

DETAILS OF PROPERTY DESTROYED OR DAMAGED

Please note:

1) Property damaged, lost or stolen is to be described in detail.
2) Invoices/Receipts showing date, price, and place of purchase of the articles set out below should accompany this form.
3) A set of colour photographs depicting the damage and/or CCTV footage showing circumstances of incident are to be submitted to us.
4) Police Report and/or Incident Report are to be submitted to us.
5) Assessment report from the repairer on the cause and extent of the damaged property is to be submitted to us.
6) At least 2 quotations for repair/replacement of the lost or damaged property are to be submitted to us. If the property is not repairable, a letter from repairers to that effect should be forwarded. All salvage must be retained.
7) The insured must promptly take all possible steps to trace/recover the property lost and in the case of theft to discover and punish the guilty party / parties.
8) Policyholder/Insured has a duty to take immediate action to mitigate loss by taking necessary measures to minimize and present further loss or damage..

DESCRIPTION OF PROPERTY LOST OR DAMAGED	QUANTITY	ORIGINAL PURCHASE PRICE	PURCHASE DATE	AMOUNT TO BE CLAIMED
(Please use supplementary sheet if necessary)				
			TOTAL AMOUNT CLAIMED	

Did you remove or save any property immediately before or during the occurrence? ☐ Yes ☐ No	If yes, how much and where is it located now?
Are you the sole owner of the property/article lost or damaged? ☐ Yes ☐ No	If no, please state name, address & relationship.

ANNUAL TRAVEL (IF APPLICABLE)

DETAILS OF INJURY / ILLNESS

Please note:

1. Personal Accident – please enclose Police Report (if any), Detailed Medical Report, and Original Medical Certificate.
2. Medical or Post Journey Medical Expenses – please enclose Original Detailed Pre-Medical / Final Hospitalization / Post-Medical Bills, Detailed Medical Report / Memo from Attending Physician on the type of illness or injury sustained.
3. Emergency Travel Expenses – please enclose Certified True Copy of Death Certificate & Proof of Relationship or written advice from the Attending Physician indicating the need to travel to or remain with the Insured Person with Original Hospital Invoices & Receipts of travel and accommodation expenses incurred.

1. Date, time and place of Accident / Illness

2. Is it due to Illness ☐ Yes ☐ NO. If yes, please state the type of Illness:

3. When did first symptoms appear? When did you first receive medical attention for this condition?

4. Please provide name and address of attending physician.

5. Have you suffered from the same condition before? ☐ Yes ☐ No. If yes, please provide details.

Date(s) of Consultation(s)

Name & Address of the Attending Physician

Amount of medical expenses paid	Amount of medical expenses recovered from other sources	Amount claimed in respect of medical expenses and similar expenses

TRIP CANCELLATION

Please note:
1. Personal Accident Trip Cancellation & Curtailment – please enclose documentary proof on relevant expenses incurred as a result of this trip cancellation, original booking invoice, Death Certificate, Medical Report &/or Written Memo from Attending Physician to cancel trip, Proof of Relationship, Travel Agents confirmation of the amount of refund.
2. Trip Curtailment – please enclose Original Invoice / Receipt of charges incurred in amending or purchasing additional air ticket.

When and Where was the trip booked?	Intended Date of Departure
Reason(s) for trip cancellation / curtailment?	Date of Cancellation of Trip
Breakdown of amount claimed	Total amount paid by you Total amount recovered from other sources Net amount claimed

If trip cancellation / curtailment were caused by medical condition, has the Patient suffered from this condition before? ☐ Yes ☐ No
If yes, please state:

Date(s) of Consultation(s)

Name and Address of Attending Physician consulted

LOSS OR DAMAGE TO BAGGAGE / PERSONAL EFFECTS

Please note:
1. Losses must be reported to the Police Authority, responsible Hotel Management or responsible officer of any aircraft, vessel / conveyance within 24 hours from the date of occurrence.
2. Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Property Irregularity Report for losses in carriers' custody, Original Purchases Bills, Photographs of damaged items, Original Repair Bills for damaged items, If the responsible Hotel Management or carrier has made compensation to the damaged/lost items, please request them to issue a note or letter certifying the amount of money paid to you.
3. Please enclose Police Report or report issued by responsible Hotel Management or carrier evidencing such losses, Original Receipts for replacement of travel documents, Original Transportation / Hotel Bills incurred for replacement of travel documents.

If the loss or damage occurred whilst baggage was in transit or otherwise in the custody or control of others, have any steps been taken to claim against these persons?	☐ Yes. Please identify them, attach any correspondence and advise outcome of your claim against them. ☐ No. Please state reason(s):
If claim is in respect of articles stolen or lost, has a thorough search been made and notification sent to the Airlines, Ship Owners, Hotel Proprietors, Police or other parties who may be able to assist in the recovery?	☐ Yes. Please give details ☐ No. Please state reason(s):

DESCRIPTION OF ITEM (MAKE & MODEL)	WHEN AND WHERE PURCHASED	ORIGINAL PURCHASE PRICE	AMOUNT RECOVERED FROM OTHER SOURCES	AMOUNT TO BE CLAIMED
(Please use supplementary sheet if necessary)				

TRAVEL DELAY / BAGGAGE DELAY

Please Note:
1. Departure and Arrival Point must be the Insured Person's Country of Residence.
2. Travel Delay – please enclose travel itinerary, boarding pass showing the actual take off time & date, written confirmation from carrier/airline or their agents specifying reason and hours of delay.
3. Baggage Delay – please enclose travel itinerary, written confirmation from carrier/airline or their agents specifying reason and the number of hours of baggage delay, Property Irregularity Report, Acknowledgement Receipt of baggage received.

ORIGINAL FLIGHT DETAILS	DELAYED FLIGHT DETAILS	COLLECTION OF DELAYED BAGGAGE
Original Departure Date, Time and Place	Rescheduled Departure Date, Time and Place	Original Arrival Date, Time and Place
Original Arrival Date, Time and Place	Rescheduled Date, Time and Place	Received Date, Time and Place
Flight No. Name of Airline	Flight No. Name of Airline	
Cause of Delay		
Amount recovered from other sources		
Amount to be claimed		

PERSONAL LIABILITY

Please note:
1. In no circumstances should the issue on legal liability be admitted to any third party claimant(s).
2. Please enclose letters/summons/writs from the third party/police/court.

Please provide details of the circumstances	
Was the accident due to carelessness or negligence on your part?	☐ Yes ☐ No
Have you in any way admitted liability?	☐ Yes ☐ No

Names & Addresses of any witnesses to the accident		
To which Police Officer and Police Station (if any) did you report the accident / damage?		
Names & Addresses of the other party(s)		
Nature of personal injury sustained by any person (please attach photographs, if any)	**Name / Age**	**Nature of Injury**
Extent of damage to property belonging to other party(s) (Please attach photographs, if any)		
Whether any claim has been made upon you. If so, was the amount of such claim specified?	☐ Yes ☐ No If yes, please state the amount:	
Please provide any additional information which you consider would help us in dealing with any claim that may be made against you		

OTHER INFORMATION

Name of Police Station, Carrier / Airline or other authorities where Report is lodged (if applicable)

DETAILS OF CLAIM *(Please use supplementary sheet if necessary)*	**AMOUNT TO BE CLAIMED**

HOSPITALISATION CASH (IF APPLICABLE)

DETAILS OF INJURY

1. Describe in detail the injuries sustained, indicating the part of the body injured and the type of injury (eg. Fracture, cut, bruise, etc.).	
2. Has the same part been injured previously?	( ) Yes ( ) No
3. Name and Address of doctor(s) who treated you and consultation date(s).	
4. Name and Address of your usual family physician.	
5. Details of hospitalization (please attach discharge note & hospital bill): (b) Name of hospital (b) Period of hospitalization	(a) (b) Date Admitted _____ Date Discharged _____

DETAILS OF ILLNESS

1. Describe in detail the symptoms leading to the discovery of the illness and/or hospitalization	

2. When did you first start to have symptoms of the illness or consult the doctor for these symptoms?	
3. Name and Address of doctor(s) who you consulted with on the onset of these symptoms and consultation date(s).	
4. Name and Address of your usual family physician.	
5. Details of hospitalization (please attach discharge note & hospital bill): (a) Name of hospital (b) Period of hospitalization	(a) (b) Date Admitted _____ Date Discharged _____
6. Have any of your family members suffered from a similar illness? If yes, please provide details.	Relationship with policyholder/insured/claimant: Nature of Illness: Date of Diagnosis

ANY OTHER INSURANCE

1. Is this a job related injury?
   If yes, please attach a copy of the i-report to the Ministry of Manpower.

2. Are you claiming from any other insurance company or other insurance company or other sources in respect of this loss / injury?
   If yes, please state:

Name of Insurance Company	Policy No.	Date Insurance Effected	Amount of Benefits

3. Have you ever made a claim against any other insurers previously? If yes, please state:

Name of Insurance Company	Date of Accident	Nature of Injury	Amount of Compensation

BANK ACCOUNT DETAILS

Name of Account Holder (as per bank account)	Bank Code
Bank Name	Branch Code
Bank Account No.	Swift Code

* Important Notice: The Company shall (i) be discharged from all liability under this claim and (ii) not be liable for any and all losses incurred by you, as a result of you providing the Company with an inaccurate bank account number under this section for the payment of this claim.

*I/We do solemnly and sincerely declare that the information given is true and correct to the best of my/our knowledge and belief. *I/We understand that any false or fraudulent statements or any attempt to suppress or conceal any material facts shall render the Policy void and we shall forfeit our rights to claim under the Policy.

PERSONAL DATA

In addition to the declaration and authorisation provided above, I/we agree and consent to the Company, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents collecting, using, disclosing and sharing amongst themselves my/our personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate, admit, process and/or administer my/our claims. These purposes are set out in HL Assurance Pte Ltd Privacy Statement, which is accessible at: https://www.hlas.com.sg/PolicyOnPersonalData.aspx and which I/we confirm I/we have read and understood.

DECLARATION AND AUTHORISATION

1. I/We declare that the above information is true and complete to the best of my knowledge and belief.
2. I/We agree that the Policy shall be void and I/We shall forfeit all rights to recover if I/We have made or were to make any false or fraudulent statements, or withhold material facts whatsoever in respect of this claim.
3. I/We hereby authorise any doctor or any other person, who has ever medically attended to the Insured Person, or any Hospital in which he or she has been treated to disclose any relevant knowledge or information which they acquired, to HL Assurance Pte. Ltd. or their Authorised Representative.
4. I/We hereby request and authorise HL Assurance Pte. Ltd. to pay benefit due in respect of this claim to _____.

Name & Signature of Policyholder _____ Date _____

Name & Signature of Insured Person / Claimant _____ Date _____

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